EXHIBIT B
PART 2

COVERED MEDICAL SERVICES (continued)

HOSPICE CARE BENEFIT

Covered Expense for Hospice Care as described below is payable under this Policy. Benefits for a **Hospice Care Program** must be furnished in a **Hospice Facility** or in **Your** home by a **Hospice Care Agency**. A physician must certify that **You** are terminally ill with a life expectancy of six months or less. For this benefit only, **Your** immediate family is considered to be **Your** parent, spouse and **Your** children or step-children.

Covered Expense is only payable when:

1. **Preauthorization** is received from **Us**; and

2. Hospice Care is in lieu of a **Confinement** in a **Hospital** or **Skilled Nursing Facility**.

If the above criteria are not met, NO benefits will be payable under this Policy for Hospice Care.

Hospice Care benefits are payable as shown on the Schedule of Benefits for the following hospice **Services**, subject to the Policy Lifetime Maximum benefit:

1. Room and board;

2. Other **Services**;

3. Part-time nursing care provided by or supervised by an R.N. for up to eight hours per day;

4. Counseling by a licensed:

   A. Clinical social worker; or

   B. Pastoral counselor for the **Hospice Patient** and the immediate family. This counseling is limited to a total of 15 visits per family;

5. Medical social services provided to **You** or **Your** immediate family under the direction of a **Qualified Practitioner**, up to a maximum benefit of $100, including:

   A. Assessment of social, emotional and medical needs, and the home and family situation; and

   B. Identification of the community resources available;

6. Psychological and dietary counseling;

7. Physical therapy;

8. Part-time home health aide **Services** for up to eight hours in any one day; and

9. Medical supplies, drugs and medicines prescribed by a **Qualified Practitioner**.

COVERED MEDICAL SERVICES (continued)

HOSPICE CARE BENEFITS DO NOT INCLUDE:

1. Private duty nursing when confined in a **Hospice Facility**;
2. A **Confinement** not required for pain control or other acute chronic symptom management;
3. Funeral arrangements;
4. Financial or legal counseling, including estate planning or drafting of a will;
5. Homemaker or caretaker **Services**, including:
   A. Sitter or companion **Services**;
   B. Housecleaning;
   C. Household maintenance;
6. **Services** of a social worker other than a licensed clinical social worker;
7. **Services** by volunteers or persons who do not regularly charge for their **Services**;
8. **Services** by a licensed pastoral counselor to a member of his or her congregation. These are **Services** in the course of the duties to which he or she is called as a pastor or minister; and
9. Bereavement counseling **Services**.

COVERED SERVICES-MENTAL HEALTH

INCLUDES MENTAL DISORDERS AND SUBSTANCE ABUSE

Limited benefits are payable for **Covered Expense** incurred for the treatment of **Mental Disorders**, and chemical and alcohol dependence.

Covered Expense includes:

1. Charges made by a **Qualified Practitioner**;
2. Charges made by a **Hospital**; and
3. Charges made by a **Qualified Treatment Facility**.

Substance Abuse:

Substance abuse means that term as defined in Section 6107 of Act. No. 368 of the Public Acts of 1978, being Section 333.6107 of the Michigan Complied Laws, for chemical and alcohol dependence.

Intermediate Care means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

1. Chemotherapy;
2. Counseling;
3. Detoxification services; or
4. Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

Outpatient Care means the use, on both a scheduled and non-scheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

1. Chemotherapy;
2. Counseling;
3. Detoxification services; or
4. Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

COVERED SERVICES-MENTAL HEALTH (continued)

The Calendar Year Maximum Benefit for **Covered Expenses** for treatment of Substance Abuse for each **Covered Person** is adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index (C.P.I.) for the 12-month period ending the preceding December 31. Contact **Us** for the current calendar year maximum benefit payable by the Policy.

BENEFITS FOR MENTAL DISORDERS AND SUBSTANCE ABUSE ARE PAYABLE AS SHOWN ON YOUR SCHEDULE OF BENEFITS.

MEDICAL BENEFITS - LIMITATIONS AND EXCLUSIONS

The Policy does NOT provide benefits for:

1. **Services** not **Medically Necessary** for diagnosis and treatment of a **Bodily Injury** or **Sickness**;

2. Any **Service** which is **Experimental, Investigational, or for Research Purposes**, unless otherwise indicated in this Certificate;

3. **Services**:

   A. Not furnished by a **Qualified Practitioner** or **Qualified Treatment Facility**;

   B. Not authorized or prescribed by a **Qualified Practitioner**;

   C. For which no charge is made, or for which **You** would not be required to pay if **You** did not have this insurance, unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law;

   D. Furnished by or payable under any plan or law through a Government or any political subdivision, unless prohibited by law;

   E. Furnished while **You** are confined in a **Hospital** or institution owned or operated by the United States Government or any of its agencies for any service-connected **Sickness** or **Bodily Injury**;

   F. Which are not rendered;

   G. That are not listed as **Covered Expense**;

   H. Provided by a person who ordinarily resides in **Your** home or who is a **Family Member**;

   I. Any **Hospital**, ancillary or other **Service** performed in association with a **Service** that is not covered under this plan;

   J. That are billed separately as professional **Services**, when the procedure requires only a technical component (CPT code) that gives a numerical or self-explanatory result and does not require professional intervention or interpretation; or

   K. That are billed incorrectly or billed separately, but are an integral part of another billed **Service**, as determined by **Us**;

4. Any drug, medicine, or device which does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Premarket Approval, or 510K;

5. Charges in excess of the **Maximum Allowable Fee** for the **Service**;

6. **Pre-Existing Conditions** to the extent specified in this Certificate and on the Schedule of Benefits;

7. **Custodial Care** and **Maintenance Care**;

MEDICAL BENEFITS - LIMITATIONS AND EXCLUSIONS (continued)

8. **Cosmetic Surgery** or any complication therefrom, unless for Reconstructive **Surgery**:

   A. Resulting from:

      i) A **Bodily Injury**, infection or other disease of the involved part; or

      ii) Congenital disease or anomaly of a covered **Dependent** child which resulted in a functional defect; or

   B. For a **Covered Person**, who is receiving benefits in connection with a mastectomy for:

      i) Reconstructive **Surgery** of the breast on which the mastectomy has been performed; and

      ii) **Surgery** and reconstruction of the other breast to achieve symmetrical appearance.

9. Any artificial means to achieve pregnancy or ovulation, including but not limited to, artificial insemination, in vitro fertilization, spermatogenesis, GIFT, ZIFT, tubal ovum transfer, embryo freezing or transfer, sperm banking, and all related fertility testing and treatment;

10. Elective abortions, reversal of sterilizations, or medical care or **Surgery** to change gender;

11. Treatment of normal pregnancy and well baby expenses, unless provided on the Schedule of Benefits;

12. Any **Expense Incurred** after the date **Your** coverage under this Policy terminates;

13. Eye refractive disorders, eyeglass frames and lenses or contact lenses, or radial keratotomy and any other **Surgery** to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises), unless specifically described in this Certificate;

14. Routine physical, hearing, or eye exams:

   A. For occupation, employment, school, travel, the purchase of insurance, or premarital tests or examinations;

   B. For health checkups, unless otherwise indicated in this Certificate;

15. **Sickness** or **Bodily Injury** for which there is medical payment or expense coverage provided or payable under any automobile, homeowners, premises, or any other similar coverage. Payments made by any other coverage will be credited toward any applicable calendar year **Deductible** and **Coinsurance** for the year the **Sickness** or **Bodily Injury** was initially sustained;

16. Dental **Services**, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral or periodontal **Surgery** and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental **Services** related to a **Bodily Injury** or **Sickness** unless otherwise indicated in this Certificate;

MEDICAL BENEFITS - LIMITATIONS AND EXCLUSIONS (continued)

17. Any loss contributed to or caused by:

    A. War or any act of war, whether declared or not; or

    B. Any act of armed conflict, or any conflict involving armed forces of any authority;

18. The treatment of **Mental Disorders**, chemical or alcohol dependence unless specifically provided in the Mental Health Covered Services provision of this Certificate and shown on **Your** Schedule of Benefits;

19. Private duty nursing while confined in a **Hospital**, **Qualified Treatment Facility** or other institution;

20. Loss due to commission or attempt to commit a civil or criminal battery or felony;

21. Any charges, including **Qualified Practitioner** charges, which are incurred if **You** are admitted to a **Hospital** on a Friday or Saturday unless;

    A. **Your Hospital** admission is due to **Emergency Care**; or

    B. Treatment or **Surgery** is performed on that same day;

22. **Services** rendered by a standby physician or assistant surgeon unless **Medically Necessary**;

23. Therapy and testing for treatment of allergies, including but not limited to **Services** related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment UNLESS such therapy or testing is approved by:

    A. The American Academy of Allergy and Immunology, or

    B. The Department of Health and Human Services or any of its offices or agencies;

24. Any treatment to reduce obesity including, but not limited to, surgical procedures;

25. Treatment of nicotine habit or addiction, including but not limited to nicotine patches, hypnosis, smoking cessation classes or tapes;

26. Vitamins, dietaries, and any other non-prescription supplements;

27. Educational or vocational therapy, **Services** and schools, including but not limited to videos and books;

28. Treatment of weak, strained, flat, unstable or unbalanced feet, arch supports, heel wedges, lifts, orthopedic shoes, or the fitting of orthotics to aid walking or running;

29. Communications, lodging accommodations, and transportation or travel time;

MEDICAL BENEFITS - LIMITATIONS AND EXCLUSIONS (continued)

30. Charges for **Services** that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including but not limited to air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;

31. Hearing aids, hair prosthesis, hair transplants or implants, and wigs;

32. Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;

33. Medications, drugs or hormones to stimulate growth unless there is a laboratory confirmed diagnosis of growth hormone deficiency;

34. Sleep therapy or **Services** rendered in a premenstrual syndrome clinic, or holistic medicine clinic;

35. Prescription drugs dispensed at any given time in excess of a 30-day supply;

36. Inpatient **Hospital Services** when **You** are in **Observation Status**;

37. Massage therapy;

38. Immunizations required for foreign travel for **Covered Persons** of any age;

39. Treatment of any **Bodily Injury** or **Sickness** that is sustained by an **Employee** or a covered **Dependent** that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the **Employee** or covered **Dependent.**

    This exclusion does not apply to the following **Employees** of the **Employer** that are or may be eligible for coverage under any Workers' Compensation Act or similar law when the **Employer** is given the option to apply for such coverage by such Act or law and the **Employer** did not apply for such coverage; provided 24-hour medical coverage was selected by the **Employer** on the Group Application, and which application was approved by **Us**, and the required additional premium was paid to us:

    A. Sole proprietor, if the **Employer** is a proprietorship;

    B. A partner of the **Employer**, if the **Employer** is a partnership;

    C. An executive officer of the **Employer**, if the **Employer** is a corporation.

COORDINATION OF BENEFITS

If **You** are covered under any plans defined below, **Covered Expense You** incur under this Plan will be coordinated with benefits payable under the other Plans defined below.

BENEFITS SUBJECT TO THIS PROVISION

Medical benefits described in this Certificate are coordinated with medical and dental benefits provided by other group insurance plans under which **You** are also covered. This is to prevent the problem of overinsurance and a resulting increase in the cost of medical coverage.

DEFINITIONS

1. **PLAN**

   For this purpose a Plan is one which covers medical or dental expenses and provides benefits or service through:

   A. Group insurance coverage;

   B. Hospital service prepayment plan on a group basis, medical service prepayment plan on a group basis, group practice or other prepayment coverage on a group basis; and

   C. Any coverage under labor-management plan, employer plans, trustee plans, union welfare plans, employee benefit organization plans.

   Employers' Plans under the same Trust Policy are considered separate Plans.

   This Coordination of Benefits provision does NOT apply to Blanket Student Accident Insurance provided by or through an educational institution. Any coverage under governmental programs, or any coverage mandated by state statute, or sponsored or provided by an educational institution, will be appropriately coordinated if such coverage is not otherwise excluded from the calculation of benefits under this Policy. The term "Plan" does not apply to any individual policies.

   The term "Plan" is construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

2. **ALLOWABLE EXPENSE**

   Allowable Expense means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plan(s) covering the person for whom claim is made.

   When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid.

COORDINATION OF BENEFITS (continued)

3. **CLAIM DETERMINATION PERIOD**

Claim Determination Period means calendar year, except that if in any calendar year the person is not covered under this Policy for the full calendar year, the Claim Determination Period for that year will be that portion during which he or she was covered under this Policy.

EFFECT ON BENEFITS

We will apply these provisions when **You** incur Allowable Expenses during a Claim Determination Period for which benefits are payable under any other Plan(s). The provisions will apply only when the sum of the **Covered Expense** under this Policy and any other Plan(s) would, in the absence of these Coordination of Benefits provisions or any similar provisions in the other Plan(s), exceed the Allowable Expenses.

Benefits provided under this Policy during a Claim Determination Period for Allowable Expenses incurred by **You** will be determined as follows:

1. If benefits under this Policy are to be paid after benefits are paid under any other Plan, the benefits under this Policy will be reduced so that the sum of the benefits so reduced plus the benefits payable under all other Plans will not exceed the total of the Allowable Expenses.

2. If benefits under this Policy are to be paid before benefits are paid under any other Plan, benefits under this Policy will be paid without regard to other Plan(s).

Covered Expense under any other Plan includes the benefits that would have been payable had claim been made.

Under no circumstances will **Your** reimbursement exceed 100% of the total Allowable Expenses incurred under this Policy and any other Plans included under this provision.

ORDER OF BENEFITS DETERMINATION

For the purpose of the Effect on Benefits provision above, the rules establishing the Order of Benefits Determination are:

1. The benefits of a Plan which covers the person on whose expenses claim is based other than as a **Dependent** are determined before the benefits of a Plan which covers such person as a **Dependent**.

2. The benefits of a Plan which covers the person on whose expenses claim is based as a **Dependent** are determined according to which parent's birthdate occurs first in a calendar year, excluding year of birth. If the birthdates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined first, except if a claim is made for a **Dependent** child:

   A. When parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a **Dependent** of a parent with custody of the child are determined before the benefits of a Plan which covers the child as a **Dependent** of the parent without custody.

COORDINATION OF BENEFITS (continued)

B. When parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a **Dependent** of the parent with custody are determined before the benefits of a Plan which covers that child as a **Dependent** of the step-parent, and the benefits of a Plan which covers that child as a **Dependent** of the step-parent are determined before the benefits of a Plan which covers that child as a **Dependent** of the parent without custody.

C. Notwithstanding provisions "A" and "B," if there is a court decree which should otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to a child, the benefits of a Plan which covers the child as a **Dependent** of the parent with such financial responsibility are determined before the benefits of any other Plan which covers the child as a **Dependent** child.

3. When rules 1. and 2. do not establish an Order of Benefits Determination, the benefits of a Plan which covers the person on whose expense claim is based as a laid-off or retired **Employee** or as the **Dependent** of such person are determined after the benefits of a Plan which covers such person through present employment.

4. When rules 1., 2. and 3. do not establish an Order of Benefits Determination, the benefits of a Plan which has covered the person on whose expense claim is based for the longer period of time are determined before the benefits of a Plan which has covered such person the shorter period of time.

5. If the provisions under the other Plan determining the effect of its Coordination of Benefits provision or exclusion are irreconcilable with the above rules, this Policy will waive application of the above rules and incorporate the rules identical with those of the other Plan.

When these provisions reduce the total amount of benefits otherwise payable to **You** under this Policy during any Claim Determination Period, each benefit that would be payable in the absence of this provision is reduced proportionately and such reduced amounts are charged against any applicable benefit limit of this Policy.

RIGHT TO NECESSARY INFORMATION

We may require certain information in order to apply and coordinate these provisions with other Plans. To obtain the needed information, **We**, without **Your** consent, will release or obtain from any insurance company, organization or person information needed to implement this provision. **You** agree to furnish any information **We** need to apply these provisions.

COORDINATION OF BENEFITS WITH MEDICARE

In all cases, Coordination of Benefits with Medicare will conform with Federal Statutes and Regulations.

If **You** are eligible for Medicare benefits, but not necessarily enrolled, **Your** benefits under this Policy will be coordinated to the extent benefits otherwise would have been payable under Medicare as allowed by Federal Statutes and Regulations.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

COORDINATION OF BENEFITS (continued)

FACILITY OF PAYMENT

Payments made under any other Plan which according to these provisions should have been made by **Us**, will be adjusted by **Us**. To do this, **We** reserve the sole right to pay the organization(s) which made such payments the amount(s) the Company determines to be warranted. Any amount(s) so paid are regarded as benefits paid under this Policy. **We** will be fully discharged from liability under this Policy to the extent of any payment so made.

RIGHT OF RECOVERY

We reserve the right to recover benefit payments made for Allowable Expenses under this Policy in the amount by which the payments exceed the maximum amount **We** are required to pay under these provisions. This Right of Recovery applies to **Us** against:

1. Any person(s) to, for or with respect to whom such payments were made; or

2. Any other insurance companies or organizations which according to these provisions owe benefits for the same Allowable Expense under any other Plan.

We alone shall determine against whom this Right of Recovery will be exercised.

EXTENDED BENEFITS

If **You** are **Totally Disabled** as a result of a covered **Bodily Injury** or **Sickness** existing on the date **You** terminate coverage under the Employer's group medical insurance plan, **We** will continue to provide medical benefits for the disabling condition until the earliest of the following:

1. The date **Your Qualified Practitioner** certifies **You** are no longer **Totally Disabled;**

2. The date **You** receive benefits equal to any maximum benefit shown on the Schedule of Benefits;

3. The end of 12 consecutive months immediately following the date **Your** coverage terminated. The 12 month period begins on the day **Your** coverage terminated and ends 12 months later on the same calendar day.

The termination of **Your Employer's** participation under this Policy will NOT terminate Extended Benefits.

The Extended Benefits provision applies only to **Covered Expenses** for the disabling condition which existed on the date **Your** coverage terminated.

REPLACEMENT

ENTIRE GROUP REPLACEMENT

APPLICABILITY

The Replacement provision applies when the **Employer's** previous group medical insurance plan is terminated and replaced within 90 days by coverage under this Policy and:

1. **You** are eligible to become insured for medical coverage on the effective date of the **Employer's** participation under this Policy; and

2. **You** were validly covered under the **Employer's** previous employer based medical plan (Prior Plan) on the day before the effective date of the **Employer's** participation under this Policy.

Benefits are NOT payable under this Policy for medical expense due to any **Bodily Injury** or **Sickness** for which **You** are entitled to receive benefits during any extension period provided by the Prior Plan.

DELAYED EFFECTIVE DATE

If any Delayed Effective Date provision described in this Certificate applies to **You** on the date **You** are otherwise eligible to become insured under this Policy, **We** will waive that provision. Medical coverage as set forth in this Certificate is then provided to **You** until the earlier of the following dates:

1. The last day of the 12 consecutive month period following the effective date of the **Employer's** participation under this Policy; or

2. The date **Your** medical coverage would otherwise terminate according to the TERMINATION OF COVERAGE provision stated in this Certificate.

If the Delayed Effective Date provision ceases to apply to **You** before 1. or 2. above occurs, **Your** medical coverage will continue without break.

DEDUCTIBLE/COINSURANCE AMOUNT

Medical **Expense Incurred** while **You** were covered under the Prior plan may be used to satisfy **Your** deductible/coinsurance amount under this Policy if:

1. The **Expense Incurred** was applied to the deductible/coinsurance amount under the Prior Plan during the ninety days preceding the effective date of this Policy; and

2. The **Expense Incurred** qualifies as a **Covered Expense** under this Policy; and

3. The **Expense Incurred** would have served to partially or fully satisfy the deductible/coinsurance amount under this Policy for the calendar year in which **Your** coverage becomes effective.

REPLACEMENT (continued)

PRE-EXISTING CONDITIONS

If a **Bodily Injury** or **Sickness** is a **Pre-Existing Condition** as stated on the Schedule of Benefits but would not have been a **Pre-Existing Condition** under the Prior Plan had it remained in force, it will not be a **Pre-Existing Condition** under this Policy.

If a **Bodily Injury** or **Sickness** is a **Pre-Existing Condition** under both the Prior Plan and this Policy, any benefits payable are applicable only to medical expenses which were incurred after the date such **Bodily Injury** or **Sickness** would no longer have been a **Pre-Existing Condition** under the Prior Plan had it remained in force.

The amount payable for such **Bodily Injury** or **Sickness** will be the lesser of:

1. The benefits payable under this Policy regardless of any **Pre-Existing Condition** Limitation; or

2. The benefits that would have been payable under the Prior Plan had it remained in force reduced by any amount actually paid by the Prior Plan for such **Bodily Injury** or **Sickness**.

However, this does NOT apply to any **Bodily Injury** or **Sickness** for which **You** are entitled to receive benefits during any extension period provided by the Prior Plan.

GENERAL PROVISIONS

NOTICE OF CLAIM

NOTICE OF CLAIM

Written notice of claim, other than claim for loss of life, must be given within 30 days after the date of loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice must be given at **Our** address shown on **Your** identification card. Notice should include **Your** name and the name(s) of **Your Dependent(s)** and **Your** Group Number.

Written notice of claim for loss of life must be furnished to **Us** within 12 months after the date of death. If a death claim is filed later, **We** must have proof that it was not possible for the claim to be filed within 12 months.

CLAIM FORMS

Upon receipt of notice of claim, **We** will send **You** the forms for filing proof of loss. If the forms are not sent to **You** within 15 days, **You** will have met the proof of loss requirement by sending **Us** a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS

You must give written proof of loss within 90 days after the date of loss, except for loss of life. **Your** claim will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written notice must be given within one year after the date proof of loss is otherwise required, except if **You** were legally incapacitated.

TIME OF PAYMENT OF CLAIMS

Payments due under this Policy will be paid upon receipt of written proof of loss.

CLAIM APPEAL PROCEDURE

If **We** partially or fully deny a claim for benefits submitted by **You**, and **You** disagree or do not understand the reasons for this denial, **You** may appeal this decision. **You** have the right to:

1. Request a review of the denial;

2. Review pertinent plan documents; and

GENERAL PROVISIONS (continued)

3. Submit in writing, any data, documents or comments which are relevant to **Our** review of this denial.

Your appeal must be submitted in writing within 60 days of receiving written notice of denial. **We** will review all information and send written notification within 60 days of **Your** request.

INCONTESTABILITY

After **You** are insured without interruption for two years, **We** cannot contest the validity of **Your** coverage except for:

1. Nonpayment of premium;
2. **Your** ineligibility under the Policy;
3. Any Policy provision;
4. Any fraudulent misrepresentation made by **You**; or
5. Any defenses **We** may have by law.

No statement made by **You** can be contested unless it is in a written form signed by **You**. A copy of the form must be given to **You** or **Your** beneficiary.

An independent incontestability period begins for each type of change in coverage or when **We** require a new Employee Enrollment Form.

This provision only limits **Our** right to void **Your** coverage after **You** have been insured without interruption for two years.

FRAUD

If **You** commit fraud against **Us** or **Your Employer** commits fraud pertaining to **You** against **Us** as determined by a court of competent jurisdiction, **Your** coverage ends automatically, without notice.

TIME LIMIT ON CERTAIN DEFENSES

A claim will not be reduced or denied after two years from the effective date of the benefit because a disease or physical condition not excluded and causing the loss existed before the benefit effective date.

CLERICAL ERROR, MISSTATEMENT OF AGE OR GENDER

If it is determined that information about the age or gender of **You** or **Your Dependents** was omitted or misstated in error, the amount of insurance for which **You** are properly eligible will be in effect. An equitable premium adjustment will be made. This provision applies equally to **You** and to **Us**. If the error was determined after six months from the effective date of **Your** coverage, no adjustment will be made.

GENERAL PROVISIONS (continued)

DUPLICATING PROVISIONS

If any charge is described as covered under two or more benefit provisions, **We** will pay only under the provision allowing the greater benefit. This may require **Us** to make a recalculation based upon both the amounts already paid and the amounts due to be paid. **We** have NO liability for benefits other than those this Policy provides.

WORKERS' COMPENSATION NOT AFFECTED

This Policy is not issued in lieu of, nor does it affect any requirement for coverage by any Worker's Compensation or Occupational Disease Act or Law.

PAYMENT OF CLAIMS

We may pay all or a portion of any benefit provided for health care **Services** to the provider unless **You** direct otherwise in writing by the time the proof of loss is filed.

Benefits accrued on behalf of **You** or **Your** covered **Dependent** upon death will be paid, at **Our** option, to any one or more of the following:

1. **Your** spouse;
2. **Your Dependent** children, including legally adopted children;
3. **Your** parents;
4. **Your** brothers and sisters; or
5. **Your** estate.

We will rely upon an affidavit to determine benefit payment, unless **We** receive written notice of valid claim before payment is made. The affidavit will release **Us** from further liability.

Any payment made by **Us** in good faith will fully discharge **Us** to the extent of such payment.

RIGHT TO REQUEST OVERPAYMENTS

We reserve the right to recover any payments made by **Us** that were made in error.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with **Us** and when asked, assist **Us** by:

1. Authorizing the release of medical information including the names of all providers from whom **You** received medical attention;
2. Obtaining medical information and/or records from any provider as requested by **Us**;

GENERAL PROVISIONS (continued)

3. Providing information regarding the circumstances of **Your** injury or accident;

4. Providing information about other insurance coverage and benefits; and

5. Providing information **We** request to administer this Policy.

PHYSICAL EXAMINATION AND AUTOPSY

We, at **Our** expense, have the right to have **You** examined as often as **We** deem reasonably necessary. **We** may also have an autopsy performed unless prohibited by law.

LEGAL ACTIONS

You cannot bring an action at law or equity to recover a claim until 60 days after the date written proof of loss is made. **You** cannot bring such action more than three years after such proof of loss is made.

ASSIGNMENT OF BENEFITS

Assignment of Benefits may be made only with **Our** consent. An assignment is not binding until **We** receive and acknowledge in writing the original or copy of the assignment before payment of the benefit. **We** do not guarantee the legal validity or effect of such assignment.

WORKER'S COMPENSATION

If benefits are paid by **Us** and **We** determine **You** received Workers' Compensation for the same incident, **We** have the right to recover as described under the "Recovery Rights" provision. **We** will exercise **Our** right to recover against **You**.

The Recovery Rights will be applied even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. NO final determination is made that **Bodily Injury** or **Sickness** was sustained in the course of or resulted from **Your** employment;

3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by **You** or the Workers' Compensation carrier; or

4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this Policy, **You** will notify **Us** of any Workers' Compensation claim **You** make, and that **You** agree to reimburse **Us** as described above.

GENERAL PROVISIONS (continued)

MODIFICATION OF POLICY

This Policy may be modified at any time by agreement between **Us** and the Policyholder without the consent of any participating **Employer** or any **Covered Person** or any beneficiary. No modification will be valid unless approved by **Our** President or Secretary. The approval must be endorsed on or attached to this Policy. No agent has authority to modify this Policy, or waive any of the Policy provisions, to extend the time of premium payment, or bind **Us** by making any promise or representation.

PREMIUM CONTRIBUTIONS

Your Employer must pay the required premiums to **Us** as they become due. **Your Employer** may require **You** to contribute toward the cost of **Your** insurance. Failure of **Your Employer** to pay any required premium to **Us** on time will result in the termination of **Your** insurance.

GRACE PERIOD

A grace period of 31 days will be allowed for payment of each premium due. If premium due is not paid within the grace period, **We** will cancel the insurance at the end of the grace period. All due and unpaid premium, including premium for the grace period, must be paid to **Us** by **Your Employer**.

AUDIT OF BILL

We want **You** to carefully review **Your** medical bills.

If **You** find any error such as:

1. Treatment billed but not received;
2. Incorrect arithmetic; or
3. Other **Services** not received,

and the error results in an overcharge, **You** should send **Us** a copy of the bill with the error noted and the corrected bill as proof that the providers of **Service** agree to the revised charges. If **You** are correct, **We** will pay **You** 50% of **Our** savings, up to a maximum of $1,000.

The provision DOES NOT apply to duplicate billings.

RECOVERY RIGHTS

RIGHT OF SUBROGATION

If, after payments have been made under this Policy, **You** or **Your** covered **Dependents** has a right to recover damages from a responsible party, **We** will be subrogated to **Your** rights to recover. **You** or **Your** covered **Dependent** will do whatever is necessary to enable **Us** to exercise **Our** right and will do nothing after loss to prejudice it. If **We** are precluded from exercising **Our** Right of Subrogation, **We** may exercise **Our** Right of Reimbursement.

GENERAL PROVISIONS (continued)

RIGHT OF REIMBURSEMENT

If benefits are paid under this Policy and **You** or **Your** covered **Dependent** recovers from a responsible party by settlement, judgment or otherwise, **We** have a right to recover from **You** or **Your** covered Dependent an amount equal to the amount **We** paid.

ASSIGNMENT OF RECOVERY RIGHTS

This Policy contains an exclusion for **Sickness** or **Bodily Injury** for which there is Medical Payment/Expense coverage provided or payable under any automobile, homeowner's, premises or other similar coverage.

If **Your** claim against the other insurer is denied or partially paid, **We** will process **Your** claim according to the terms and conditions of this Policy. If payment is made by **Us** on **Your** behalf, **You** agree to assign to **Us** any right **You** have against the other insurer for medical expenses **We** pay.

SHARED SAVINGS PROGRAM

As a member of a Preferred Provider Organization Plan, **You** are free to obtain **Services** from providers participating in the Preferred Provider Organization network (Preferred Providers), or providers not participating in the Preferred Provider Organization network (Non-Preferred Providers). If **You** choose a Preferred Provider, **Your** out-of-pocket expenses are normally lower than if **You** choose a Non-Preferred Provider.

We have a Shared Savings Program that may allow **You** to share in discounts **We** have obtained from Non-Preferred Providers.

Although **Our** goal is to obtain discounts whenever possible, **We** cannot guarantee that **Services** rendered outside the Preferred Provider Organization network will be discounted. The Non-Preferred Provider discounts in the Shared Savings Program may not be as favorable as Preferred Provider discounts.

In most cases, to maximize **Your** benefit design and minimize **Your** out-of-pocket expense, please access **Your** Preferred Provider Organization network of providers associated with **Your** Plan.

If **You** choose to obtain **Services** from a Non-Preferred Provider, it is not necessary for **You** to inquire about a provider's status in advance. When processing **Your** claim, **We** will automatically determine if that provider is participating in the Shared Savings Program and calculate **Your Deductible** and **Coinsurance** on the discounted amount. **Your** Explanation of Benefits statement will reflect any savings with a remark code used to reference the Shared Savings Program.

However, if **You** would like to inquire in advance to determine if a Non-Preferred Provider participates in the Shared Savings Program, please call 1-800-558-4444. Please note, provider arrangements in the Shared Savings Program are subject to change without notice. **We** cannot guarantee that the provider from whom **You** received treatment is still participating in the Shared Savings Program at the time treatment is received. Discounts are dependent upon availability and cannot be guaranteed.

We reserve the right to modify, amend, or discontinue the Shared Savings Program at any time.

DISCOUNT DISCLOSURE

From time to time, **We** may offer or provide access to discount programs to persons who become insureds. In addition, **We** may arrange for third party service providers such as pharmacies, optometrists, dentists and alternative medicine providers, to provide discounts on goods and services to persons who become insureds. Some of these third party service providers may make payments to **Us** when insureds take advantage of these discount programs. These payments offset the cost to **Us** of making these programs available and may help reduce the costs of **Your** plan administration. Although **We** have arranged for third parties to offer discounts on these goods and services, these discount programs are not insured benefits under this Policy. The third party service providers are solely responsible to insureds for the provision of any such goods and/or services. **We** are not responsible for any such goods and/or services, nor are **We** liable if vendors refuse to honor such discounts. Further, **We** are not liable to insureds for the negligent provision of such goods and/or services by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.

SUPPLEMENTAL BENEFIT
PRESCRIPTION DRUG BENEFIT

This benefit Rider is attached to and made a part of **Your** Certificate. The effective date of this change is the latter of the effective date of the Certificate or the date this benefit is added to the Policy. Except as modified below, all Policy terms, conditions and limitations apply.

Notwithstanding any other provisions of the Policy to the contrary, this rider amends the Certificate to remove the benefits for coverage of Prescription drugs, medicines, or medications dispensed by a Pharmacy. Prescription drug expenses covered under this Rider are not covered under any other provision of the Policy. Any amount in excess of the maximum amount provided under this rider, if any, is not covered under any other provision in the Policy.

PRESCRIPTION DRUG COST SHARING

You are responsible for payment of the per Prescription Co-Payment.

When the **Covered Person** requests a Brand-Name Medication when a Generic Medication is available, the **Covered Person** is responsible for the applicable Generic Medication Co-Payment and 100% of the difference between the amount **We** would have paid the dispensing **Pharmacy** for the Brand-Name Medication and the amount **We** would have paid the dispensing **Pharmacy** for the Generic Medication, unless the prescribing **Qualified Practitioner** determines that the Brand-Name Medication is **Medically Necessary**, then the **Covered Person** will only be responsible for the applicable Co-Payment for a Brand-Name Medication on **Our** Drug List.

Any **Expenses Incurred** under provisions of this Rider do not apply toward the **Covered Person's Out-of-Pocket Limits**.

SCHEDULE OF BENEFITS - PRESCRIPTION DRUGS

You are required to pay the following:

Non- Maintenance Medication

Level 1 Drugs $10 Co-Payment per Prescription

Level 2 Drugs $30 Co-Payment per Prescription

Level 3 Drugs $50 Co-Payment per Prescription

Level 4 Drugs 25% Co-Payment per Prescription to a calendar year maximum Co-Payment of $2,500 per **Covered Person** for Level 4 Drugs

Maintenance Medication

For up to a 90-day supply of a Maintenance Medication, the **Covered Person** must pay three (3) time(s) the applicable Co-Payment, subject to one Co-Payment for up to a 30-day supply.

Non-Participating pharmacy

When a Non-Participating Pharmacy is used or when a **Covered Person** does not present his or her I.D. card at the time of purchase to the Participating Pharmacy the **Covered Person** will also be responsible for 30% of the actual charge made by the dispensing Pharmacy, after the applicable Co-Payment or **Coinsurance**.

DEFINITIONS

The following are definitions of terms as they are used in this rider.

BRAND-NAME MEDICATION

Brand-Name Medication means Prescription drugs, medicines, or medications that are manufactured and distributed by only one pharmaceutical manufacturer, or as defined by the national pricing standard used by **Us**.

CO-PAYMENT

Co-Payment means the amount to be paid by the **Covered Person** toward the cost of each separate Prescription or refill of a covered drug when dispensed by a Pharmacy.

DISPENSING LIMIT

Dispensing Limit means the monthly drug dosage limit and /or the number of months the drug usage is usually needed to treat a particular condition.

GENERIC MEDICATION

Generic Medication means drugs, medicines or medications that are manufactured, distributed and available from several pharmaceutical manufacturers and identified by the chemical name; or as defined by the national pricing standard used by **Us**.

LEGEND DRUG

Legend Drug means any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits dispensing without prescription".

LEVEL 1, 2, 3 or 4 DRUGS

Level 1 Drugs means a category of Prescription Drugs, medicines or medications within Our Drug List that are designated by **Us** as Level 1 Drugs.

Level 2 Drugs means a category of Prescription Drugs, medicines or medications within Our Drug List that are designated by **Us** as Level 2 Drugs.

Level 3 Drugs means a category of Prescription Drugs, medicines or medications within Our Drug List that are designated by **Us** as Level 3 Drugs.

Level 4 Drugs means a category of Prescription Drugs, medicines or medications within Our Drug List that are designated by **Us** as Level 4 Drugs.

MAINTENANCE MEDICATION

Maintenance Medication means Prescription drugs, medicines or medications that are:

1. Generally prescribed for treatment of long-term chronic **Sickness** or **Bodily Injuries**; and

2. Purchased from the Pharmacy contracted by **Us** to dispense drugs by mail order.

Maintenance Medication does not include Self-Administered Injectable Drugs, or Level 4 Drugs as designated by **Us**.

NON-PARTICIPATING PHARMACY

Non-Participating Pharmacy means a Pharmacy which has not entered into a service agreement with **Us**.

OUR DRUG LIST

Our Drug List means a list of Prescription drugs, medicines and medications and supplies specified by **Us**. This list is subject to change.

PARTICIPATING PHARMACY

Participating Pharmacy means a Pharmacy which has entered into a service agreement with **Us** to provide services under the terms set forth by **Us.**

PHARMACIST

Pharmacist means a person who is licensed to prepare and dispense medication and who is practicing within the scope of his or her license.

PHARMACY

Pharmacy means a licensed establishment where prescription medications are dispensed by a Pharmacist.

PRESCRIPTION

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The drug, medicine or medication must be obtainable only by Prescription.

The Prescription must be given by a **Qualified Practitioner** to a Pharmacist for the benefit of and use by a **Covered Person** for the treatment of a **Bodily Injury** or **Sickness**. The Prescription may be given to the Pharmacist verbally or in writing by the **Qualified Practitioner**.

The Prescription must include:

1. The name and address of the **Covered Person** for whom the Prescription is intended;
2. The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
3. The date the Prescription was prescribed; and
4. The name, address and DEA number of the prescribing **Qualified Practitioner**.

PRIOR AUTHORIZATION

Prior Authorization means the required prior approval from **Us** for the coverage of Prescription drugs, medicines, medications, including the dosage, quantity and duration, as appropriate for the **Covered Person**'s age and sex. Certain Prescription drugs, medicines or medications may require Prior Authorization.

SUPPLEMENTAL BENEFIT
PRESCRIPTION DRUG BENEFIT (continued)

SELF-ADMINISTERED INJECTABLE DRUG

Self-Administered Injectable Drug means an FDA approved medication which a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, (excluding insulin, epinephrine, sumatriptan, and glucagon) and intended for use by the **Covered Person**.

COVERAGE DESCRIPTION

Benefits are available for covered Prescription drugs, medicines or medications that are received by the **Covered Person** while he or she is covered under this Prescription Drug Benefit Rider. Benefits may be subject to Dispensing Limits and Prior Authorization requirements, if any.

Covered Prescriptions are:

1. Drugs, medicines or medications that under federal or state law, may be dispensed only by Prescription from a **Qualified Practitioner**; and

2. Limited to a maximum of a 30-day supply for a Non-Maintenance Medication per Prescription or refill (the maximum is a 30-day supply per Co-Payment based on the FDA approved dosage, regardless of manufacturers' packaging, e.g. a 90-day supply of pre-packaged inhalers would require 3 Co-Payments); and

3. Limited to a maximum of a 90-day supply for Maintenance Medication per Prescription or refill; and

4. Drugs, medicines or medications that must be included on Our Drug List; and

5. Insulin and diabetic supplies (on Prescription), which include:

   A. Strips;

   B. Glucose tabs;

   C. Lancets and lancet devices;

   D. Test solutions;

   E. Syringes;

   F. Alcohol swabs;

   G. Insulin delivery devices; and

   H. Blood glucose monitors;

6. Hypodermic needles or syringes on Prescription for use with insulin or Self-Administered Injectable Drugs; (Hypodermic needles and syringes used in conjunction with covered Level 4 Drugs may be available at no cost to **You**);

7. Self-Administered Injectable Drugs approved by Us; and

8. Spacers and/or peak flow meters for the treatment of asthma.

SUPPLEMENTAL BENEFIT
PRESCRIPTION DRUG BENEFIT (continued)

Contrary to any other provisions of the Policy, **We** may decline coverage or, if applicable, exclude from Our Drug List any and all Legend Drugs during a review period not to exceed six(6) months following FDA approval for the use and release of the Legend Drugs into the market. After the review period, a determination will be made regarding coverage status and inclusion of the Legend Drugs on Our Drug List.

ADDITIONAL LIMITATIONS AND EXCLUSIONS

Expense Incurred will not be payable under this Rider for the following:

1. Legend Drugs which are not recommended and not deemed necessary by a **Qualified Practitioner**;
2. Any drug prescribed for intended use other than for:
   A. Indications approved by the FDA; or
   B. Recognized off-label indications through peer-reviewed medical literature;
3. Any drug prescribed for a **Sickness** or **Bodily Injury** not covered under the Policy;
4. Any drug, medicine or medication labeled "Caution - Limited by Federal Law to Investigational Use" or any experimental drug, medicine or medication, even though a charge is made to the **Covered Person**;
5. Allergen extracts;
6. Therapeutic devices or appliances, including:
   A. Hypodermic needles and syringes except needles and syringes for diabetes, and Self-Administered Injectable Drugs approved by **Us**;
   B. Support garments;
   C. Test reagents;
   D. Mechanical pumps for delivery of medications; and
   E. Other non-medical substances;
7. Dietary supplements;
8. Nutritional products;
9. Fluoride supplements;
10. Minerals;
11. Growth hormones (medications, drugs or hormones to stimulate growth), unless there is a laboratory confirmed diagnosis of growth hormone deficiency;

SUPPLEMENTAL BENEFIT
PRESCRIPTION DRUG BENEFIT (continued)

12. Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride;

13. Anabolic steroids;

14. Anorectic or any drug used for the purpose of weight control;

15. Any drug used for cosmetic purposes, including but not limited to:

    A. Tretinoin, e.g. Retin A, except if **You** are under the age of 45 or are diagnosed as having adult acne;

    B. Dermatologicals or hair growth stimulants; or

    C. Pigmenting or de-pigmenting agents, e.g. Solaquin;

16. Any drug or medicine that is:

    A. Lawfully obtainable without a Prescription (over the counter drugs), except Insulin; or

    B. Available in prescription strength without a Prescription;

17. Compounded drugs in any dosage form; except when prescribed for pediatric use for children up to 19 years of age;

18. Progesterone crystals or powder in any compounded dosage form;

19. Abortifacients (drugs used to induce abortions);

20. **Infertility Services** including medications;

21. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;

22. Any oral drug, medicine or medication that is consumed or injected, at the place where the Prescription is given or dispensed by the **Qualified Practitioner**;

23. The administration of covered medication;

24. Prescriptions that are to be taken by or administered to the **Covered Person**, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:

    A. **Hospital**;

    B. Rest home;

    C. Sanitarium;

    D. **Skilled Nursing Facility**;

    E. Convalescent Hospital; or

    F. **Hospice Facility**;

SUPPLEMENTAL BENEFIT
PRESCRIPTION DRUG BENEFIT (continued)

25. Injectable drugs, including but not limited to:

    A. Immunizing agents;

    B. Biological sera;

    C. Blood;

    D. Blood plasma; or

    E. Self-Administered Injectable Drugs not approved by **Us**;

26. Prescription refills:

    A. In excess of the number specified by the **Qualified Practitioner**; or

    B. Dispensed more than one year from the date of the original order;

27. Any portion of a Prescription or refill that exceeds a 30-day supply for a Non-Maintenance Medication (or a 90-day supply for a Maintenance Medication by mail order);

28. Any portion of a Prescription or refill that:

    A. Exceeds **Our** drug specific Dispensing Limit, e.g. IMITREX; or

    B. Is dispensed to a **Covered Person** whose age is outside the drug specific age limits defined by **Us**;

    C. Exceeds the duration-specific Dispensing Limit (e.g. use of a proton pump inhibitor such as Prevacid for more than 60 or 90 days);

29. Any drug for which Prior Authorization is required, as determined by **Us**, and not obtained;

30. Any drug for which a charge is customarily not made, or for which the dispenser's charge is less than the Co-Payment amount in the absence of this benefit;

31. Any drug, medicine or medication received by the **Covered Person**:

    A. Before becoming covered under this Rider; or

    B. After the date the **Covered Person**'s coverage under this Rider has ended;

32. Any costs related to the mailing, sending or delivery of prescription drugs;

33. Any fraudulent misuse of this benefit, including Prescriptions purchased for consumption by someone other than the **Covered Person**;

34. Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;

SUPPLEMENTAL BENEFIT
PRESCRIPTION DRUG BENEFIT (continued)

35. Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to Nicotine withdrawal therapies, programs, services or medications;

36. Drug delivery implants, e.g. Norplant;

37. Treatment for Onychomycosis (nail fungus);

38. More than one Prescription for the same drug or therapeutic equivalent medication prescribed by one or more **Qualified Practitioners** and dispensed by one or more Pharmacies until at least 75% of the previous Prescription has been used by the **Covered Person**, unless the drug or therapeutic equivalent medication is a Maintenance Medication, purchased through mail order, in which case 66% of the previous Prescription must have been used by the **Covered Person** (based on the dosage schedule prescribed by the **Qualified Practitioner**);

39. Any drug or biological that has received designation as an orphan drug, unless approved by **Us**; or

40. Any Co-Payments or **Coinsurance You** paid for a Prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription.

Michael B. McCallister
President

AMENDMENT

This amendment is made part of the Policy to which it is attached. The effective date of this change is the latter of the effective date of the Certificate or the date this amendment is added to the Policy.

All terms used in this amendment have the same meaning given to them in the Policy unless otherwise specifically defined in this amendment. Except as modified below all Policy terms, conditions and limitations apply.

PREAUTHORIZATION REQUIREMENTS AND PENALTY

Notwithstanding any provision of the Policy, the following **Preauthorization** requirements now apply:

Preauthorization by **Us** is required for certain **Services** and supplies. Visit **Our** Website at www.humana.com or call the customer service telephone number on **Your** identification card to obtain a list of **Services** and supplies that require **Preauthorization**. The list of **Services** and supplies that require **Preauthorization** is subject to change. Coverage provided in the past for **Services** or supplies that did not receive or require **Preauthorization**, is not a guarantee of future coverage of the same **Services** or supplies.

You are responsible for informing **Your Qualified Practitioner** of the **Preauthorization** requirements. **You** or **Your Qualified Practitioner** must contact **Us** by telephone, electronic mail, via **Our** Website or in writing to request the appropriate authorization. **Your** ID card will show **Your Qualified Practitioner** the telephone number to call to request authorization. Benefits are not paid at all for **Services** or supplies that are not **Covered Expenses**.

If any required **Preauthorization** of **Services** or supplies is not obtained, the benefit payable for any **Covered Expenses** incurred for the **Services**, will be reduced by $500 or 50%, whichever is less, after any applicable **Deductibles** or co-payments. If the rendered **Services** are not **Covered Expenses**, no benefits are payable. The out-of-pocket amounts incurred by the **You** due to these benefit reductions may not be used to satisfy any out-of-pocket limits. This **Preauthorization** penalty will apply if **You** received the **Services** from either a Preferred Provider or a Non-Preferred Provider when **Preauthorization** is required and not obtained.

LIMITATIONS AND EXCLUSIONS

The following exclusion is added to **Your Policy**:

Services received in an emergency room unless required because of an **Emergency Care**.

Humana Insurance Company

Michael B. McCallister
President

HUMANA.
Guidance when you need it most

Toll Free: 800-558-4444
1100 Employers Blvd.
Green Bay, WI 54344
www.humana.com

INSURED BY
HUMANA INSURANCE COMPANY

ILLINOIS
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631
(773) 714-8050

Illinois Department of Insurance
320 West Washington Street, 4th Floor
Springfield, Illinois 62767
(217) 782-4515

Summary of General Purposes And Current Limitations of Coverage

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") (215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions, and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

- Coverage:
  - The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:
    - Life insurance, health insurance, and annuity contracts;
    - Life, health or annuity certificates under direct group policies or contracts;
    - Unallocated annuity contracts; and
    - Contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.
- Exclusions from Coverage
  - The Guaranty Association does not provide coverage for:
    - Any policy or portion of a policy for which the individual has assumed the risk;
    - Any policy of reinsurance (unless an assumption certificate was issued);
    - Interest rate guarantees which exceed certain statutory limitations;
    - Certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
    - Any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
    - Any stop loss insurance.
  - In addition, persons are not protected by the Guaranty Association if:

- The Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or

- Their policy was issued by an organization which is not a member insurer of the Association.

- Limits on Amount of Coverage:

  - The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. the Guaranty Association's liability is limited to the lesser of either:

    - The contractual obligations for which the insurer is liable for which the insurer would have been liable if it were not an impaired or insolvent insurer, or

    - With respect to any one life, regardless of the number of policies, contracts, or certificates:

      - In the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or withdrawal values;

      - In the case of health insurance, $300,000 in health insurance benefits, including net cash surrender or withdrawal values; and

      - With respect to annuities, $100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000 in benefits per contract holder, regardless of the number of contracts.

  - However, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

IMPORTANT NOTICE

If **You** are not satisfied with the determination by **Us** or a utilization review agent regarding services furnished or proposed to be furnished to **You**, **You** have the right to request an internal or external review, as applicable.

Prior to requesting an external review, the **Covered Person** must first exhaust the internal grievance process, with the following exceptions:

If the **Covered Person** has a medical condition that would seriously jeopardize his/her health or ability to regain maximum function the **Covered Person** or his/her designated representative may file a request for an expedited external review at the same time that a similar request is being made for an expedited internal grievance.

If **We** do not respond to an individual's internal grievance within 35 calendar days of the written submission, and without any agreement or request by the **Covered Person** or his/her designated representative to grant a delay, the **Covered Person** may file a request for an external review; then the **Covered Person** will be considered to have exhausted **Our** internal grievance process.

Upon filing request for an external review, the individual will be required to sign an authorization for the release of any pertinent medical records that may be necessary to adequately review his/her case.

You may call Humana Insurance Company's toll free telephone number at

1-800-558-4444

or write to Humana Insurance Company at

Humana Grievance & Appeals Office
P.O. Box 14618
Lexington, KY 40512-4618

You may contact the Commissioner of Insurance for assistance at any time at

PO BOX 30220
Lansing, MI 48909-7720

PHONE: 1-877-999-6442
FAX: (517) 241-4168

NOTICES

The following pages contain important information about Humana's claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

- **Women's Health and Cancer Rights Act**
- **Statement of Rights Under the Newborns' and Mothers' Health Protection Act**
- **Medical Child Support Orders**
- **General Notice of COBRA Continuation of Coverage Rights**
- **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)**
- **Family And Medical Leave Act (FMLA)**
- **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**
- **Your Rights Under ERISA**

Privacy and Confidentiality Statement

Claims and appeals procedures

Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures, Humana complies with these standards. Covered persons in insured plans subject to ERISA should also consult their insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage). Humana complies with the requirements set forth in any such benefit plan document issued by it with respect to the plan unless doing so would prevent compliance with the requirements of the federal ERISA statute and the regulations issued there under. The following claims procedures are intended to comply with the ERISA claims regulation, and should be interpreted consistent with the minimum requirements of that regulation. Covered persons in plans not subject to ERISA, should consult their benefit plan documents for the applicable claims and appeals procedures.

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits, and
- Resolve factual questions relating to coverage and benefits.

Definitions

Adverse determination means a decision to deny benefits for a *pre-service claim* or a *post-service claim* under a *group health plan*.

Claimant means a covered person (or authorized representative) who files a claim.

Concurrent-care decision means a decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a Claimant to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Group health plan means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer means the offering company listed on the face page of your Certificate of Insurance and referred to in this document as "Humana."

Post-service claim means any claim for a benefit under a *group health plan* that is not a *pre-service claim*.

NOTICES (continued)

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care claim (expedited review) means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an *urgent-care claim*. However, any claim a physician, with knowledge of a covered person's medical condition, determines is a "*urgent-care claim*" will be treated as a "claim involving urgent care."

Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Failure to provide necessary information

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five (5) days (or within 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirement, it will be returned to the submitter.

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an Urgent-care Claim will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims decisions

After a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- ***Pre-service claims*** - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives of the claim.

NOTICES (continued)

This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the *claimant* of the circumstances requiring the extension and the date by which Humana expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

- ***Urgent-care claims (expedited review)*** - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

  Notice of a favorable or *adverse determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 72 hours after receiving the *urgent-care claim*.

  If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim*. The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information – but not less than 48 hours.

  Humana will provide notice of the plan's urgent-care claim determination as soon as possible but no more than 48 hours after the earlier of:

  - The plan receives the specified information; or
  - The end of the period afforded the Claimant to provide the specified additional information.

- ***Concurrent-care decisions*** - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination.

  Humana will decide *urgent-care claims* involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- ***Post-service claims*** - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected *claimant* of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the claimant will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the claimant responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claims*, notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to *claimants*, free of charge, upon request.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

Appeals of adverse determinations

A *claimant* must appeal an *adverse determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a *claimant* by means of written application to Humana, in person, or by mail, postage prepaid.

A *claimant*, on appeal, may request an expedited appeal of an adverse *urgent-care claim* decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the *claimant* by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

On appeal, a *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

- ***Urgent-care claims*** - As soon as possible but no later than 72 hours after Humana receives the appeal request;
- ***Pre-service claims*** - Within a reasonable period but no later than 30 days after Humana receives the appeal request;
- ***Post-service claims*** - Within a reasonable period but no later than 60 days after Humana receives the appeal request;
- ***Concurrent-care decisions*** - Within the time periods specified above depending on the type of claim involved.

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse determination*;

- Reference to the specific plan provision upon which the determination is based;

- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the *claimant*, free of charge, upon request;

- A statement describing any voluntary appeal procedures offered by the plan and the *claimant's* right to obtain the information about such procedures, and a statement about the *claimant's* right to bring an action under §502(a) of ERISA;

- If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the event an appealed claim is denied, the *claimant* will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination;

- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

- Demonstrates compliance with the administrative processes and safeguards required in making the determination;

- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the *claimant's* diagnosis, without regard to whether the statement was relied on in making the benefit determination.

Exhaustion of remedies

Upon completion of the appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the *claimant* may proceed to the next level in the review process.

After exhaustion of remedies, a *claimant* may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

Federal legislation

Women's health and cancer rights of 1998
Required coverage for reconstructive surgery following mastectomies

Under federal law, group health plans and health insurance issuers offering group health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

Statement of rights under the newborn' and mothers' health protection act (NMHPA)

If your plan covers normal pregnancy benefits, the following notice applies to you.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator.

NOTICES (continued)

Medical child support orders

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

General notice of COBRA continuation coverage rights

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

NOTICES (continued)

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, the qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

NOTICES (continued)

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage with 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to at total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage - If you an anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage;

Second qualifying event extension of 18-month period of continuation coverage - If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

NOTICES (continued)

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gob/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options.

- ***Option 1*** - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.
- ***Option 2*** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

NOTICES (continued)

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- ***Category 1*** Medicare eligibles are:
  - Covered employees in active service who are age 65 or older who choose Option 1;
  - Age 65 or older covered spouses; and
  - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;
- ***Category 2*** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:
  - Retired employees and their spouses; or
  - Covered dependents of a covered employee, other than his or her spouse.

Calculation and payment of benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the *employer* as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other *employees* who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Continuation of benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

NOTICES (continued)

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of coverage

If elected, continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other information

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Under the Employee Retirement Income Security Act of 1974 (ERISA), all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

NOTICES (continued)

Participants should review their group health plan document regarding reduction or elimination of exclusionary periods for preexisting conditions due to creditable coverage from another plan. The group health plan or health insurance issuer should provide a certificate of creditable coverage when coverage ends under the plan, the participant becomes entitled to elect COBRA continuation coverage, COBRA continuation coverage ceases (if COBRA is requested before losing coverage) or, if requested, up to 24 months after losing coverage. Without evidence of creditable coverage, a participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the coverage enrollment date.

Claims determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;

- If the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;

- If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;

For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

Privacy and confidentiality statement

We understand the importance of keeping your personal and health information private (PHI). PHI includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. We are required by applicable federal and state law to maintain the privacy of your PHI.

Under both law and our policies, we have a responsibility to protect the privacy of your PHI. We:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change our privacy practices at any time, as allowed by applicable law, rules and regulations. We reserve the right to make changes in our privacy practices for all PHI that we maintain, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will send notice to our health plan subscribers. For more information about our privacy practices, please contact us.

As a covered person, we may use and disclose you PHI, without your consent/authorization, in the following ways:

Treatment: We may disclose your PHI to a health care practitioner, a hospital or other entity which asks for it in order for you to receive medical treatment.

Payment: We may use and disclose your PHI to pay claims for covered services provided to you by health care practitioners, hospitals or other entities.

NOTICES (continued)

We may use and disclose your PHI to conduct other health care operations activities.

It has always been our goal to ensure the protection and integrity of your personal and health information. Therefore, we will notify you of any potential situations where your identification would be used for reasons other than treatment, payment and health plan operations.